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Review of *Physician-Assisted Suicide* edited by Robert F. Weir

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BOOK REVIEW

PHYSICIAN-ASSISTED SUICIDE (Medical Ethics Series). Edited by Robert F. Weir. Bloomington: Indiana U Press, 1997. Pp. 304. $29.95. ISBN: 0253332826.

Is assistance in suicide a fundamental constitutional right? Should physician-assisted suicide (PAS) be legalized? These two questions have galvanized the debate over PAS for the past decade. They likewise shape the essays in this volume. It is perhaps unfortunate that these questions were answered, the second at least provisionally, in the same year this volume was published. For 1997 witnessed the landmark decisions of the Supreme Court in *Washington v Glucksberg,* 521 US 702 (1997), and *Vacco v Quill*, 521 US 793 (1997), as well as the implementation of the equally historic Oregon Death with Dignity Act (Measure 16). One wonders how the distinguished scholars gathered here might have engaged these developments in their essays.

Nonetheless, this volume provides valuable historical background and penetratingly analyzes conceptual, legal, and policy issues at stake with PAS. For legal scholars, it provides valuable models for interpreting legal decisions and public policy. Remarkable for their clarity, these essays are equally accessible to students or thoughtful citizens truly interested in how to think about and respond to PAS.

It is a credit to Robert Weir that he could produce a book like this. For he has collected a set of compelling arguments against his own position. Elsewhere, Weir has argued that PAS ought to be decriminalized.[1] His preface that introduces the essays clearly reflects this position. The preface leaves one with the impression that consensus favoring PAS is building and that legalization is only a matter of time. It was surprising, then, to find that among the ten authors (two marshaled for each section), only three clearly support PAS. While the "reasonable persons" on this panel certainly disagree, those who oppose PAS advance better arguments and are able to mount more careful, cogent and persuasive cases.

Both essays in Part One, *Historical Interpretation*, provide

1. Robert F. Weir, *The Morality of Physician Assisted Suicide*, Law, Medicine, & Health Care 20 (1992).

important contextualizing background. Readers will find themselves reading and interpreting later authors' claims in light of the narratives and accounts presented here. The book could not have begun with a better essay than Darrel W. Amundsen's, the only one in the book to deal in any way with religion. Two discrete objectives shape Amundsen's project. First, he highlights the complex issue of how historical warrants ought to be deployed in developing legal opinion. Anyone charged with writing legal decisions would profit from this piece. Second, Amundsen is clearly vexed. And he should be. The problem is identified in the title of his essay: *The Significance of Inaccurate History in Legal Considerations of Physician Assisted Suicide*. In order to undermine the challenge presented by Christian convictions, PAS advocates have engaged what can at best be labeled "revisionist history," but more accurately is simply incompetent and irresponsible scholarship. By distorting the historical corpus, inexcusably conflating martyrdom and suicide, anachronistically applying contemporary concepts to antiquity, and lacking basic socio-historical methods, such advocates have re-narrated early Christianity as either open to or actively encouraging suicide.

More importantly, bad scholarship has legs, especially bad scholarship that serves a public agenda. Trumpeted within media campaigns, such conclusions come to be believed by the general public. And they wend their way into centers of influence. Amundsen offers the example of Michigan Circuit Court Judge Kaufman's 1993 "Opinion and Order Concerning the Constitutionality of the Michigan Statute Proscribing Assisted Suicide." He pulls no punches in criticizing Kaufman's account. But he reserves his most scathing critique for a theologian and a patristic scholar, Arthur J. Droge and James D. Tabor, for their recent book, *A Noble Death: Suicide and Martyrdom among Christians and Jews in Antiquity* (Harper, 1992). Amundsen charges them with "faddish linguistic deconstructionism and historical revisionism that are blatantly anachronistic and do violence to the texts." (10)[2] Amundsen retrieves significant early Christian texts carefully, precisely, and systematically.[3] He ably refutes the claim that most Christian martyrs actually volunteered or took their own lives. He traces patristic commentary on suicide. And he demolishes the conflation between martyrdom and suicide.

Harold Y. Vanderpool locates the contemporary PAS debate within

2. All citations in the text refer to the book under review.

3. For a more developed account, highly recommended, see Edward J. Larson & Darrel W. Amundsen, *A Different Death: Euthanasia and the Christian Tradition* (InterVarsity Press, 1998).

the history of American physicians' "traditions" of thought, advocacy and practice vis-à-vis the dying of their patients. He begins with the 1847 AMA Code of Ethics, which first codified physician's responsibilities to dying patients, enjoining them to attend at the bedside, administer therapeutics and serve as "ministers of hope and comfort to the sick." Although medicalization of dying begins to emerge even within this phase, a shift occurs as the century progresses, propelled by technological developments—the invention of the hypodermic and advances in analgesics. In 1873, a new variable enters the picture, namely, a proposal from England advocating euthanasia. In Vanderpool's account, the debate over euthanasia was striking in a key regard: the arguments advanced, for and against euthanasia, are remarkably contemporary. All warrants asserted today regarding PAS—save autonomy—merely echo turn-of-the-century arguments.

Vanderpool's narrative recounts how dying became an object of control, with physicians centralizing control through the hospitalization of dying until the 1970s when movements for patient-control over medicalized dying emerged. The contemporary debate continues this struggle. Vanderpool comes closer than his colleagues to showing how patient attitudes toward end-of-life issues are so deeply constructed by technology and culture so as to render the notion of "self-determination" a tragic myth.

Moreover, he shows that it was within a relatively short time period—from 1840 to 1950—that an amazing metamorphosis occurred in the social ecology of dying. Seen in the 1840s as substantively central to one's individual life narrative, the dying process was deemed so profoundly important that "To be present at a friend's, neighbor's, or family member's death was looked upon as a 'great' or 'very great privilege." (35) By the 1950s dying had become something to be avoided. Physicians believed "that patients would be emotionally devastated if they discovered that their lives could not be prolonged" and "a 'collective mood' developed—the desire not to be present at death." (45) Vanderpool's essay demonstrates how contemporary attitudes and practices, often invoked as timeless, universal truths, are cultural artifacts of relatively recent vintage.

Part Two explores *Ethical Assessments and Positions*. Daniel Callahan and Dan W. Brock face off over whether or not PAS could ever be ethically or morally justifiable. Callahan argues that PAS is both intrinsically and consequentially wrong. The prospect of socially legitimating PAS through legalization concerns him most. Callahan methodically outlines the principal arguments against PAS. The care,

precision, and clarity of his analysis is a model of bioethical discourse. The arguments he marshals and the critiques he registers will be familiar to those acquainted with the PAS debate—that PAS concentrates excessive power in the physicians' hands, that it disproportionately values individual self-determination over the common good, that the Netherlands' experiment evidences that the practice cannot be contained, and that PAS would intrinsically alter the medical practice.

Five points are worth highlighting. Callahan first states a claim that recurs throughout the essays, namely that "the distinction between euthanasia and PAS is not morally significant." (71) In both cases, the physician is causally involved and so is equally culpable. Related to this, he notes how fictive the notion of self-determination is; insofar as both PAS and euthanasia require another person's assistance, it is "a mutual, social decision between two people." (74) Third, legalizing PAS would represent a profound turning point in Western culture, by creating "one more socially tolerated reason for one person to kill another or to assist another to kill herself." (72) This he finds incongruous, insofar as on most fronts (for example, the death penalty, war), socio-political opinion is beginning to challenge these practices.

Fourth, Callahan takes on those who would erase the distinction between killing and allowing to die. Here Callahan truly advances the debate by distinguishing between causality and culpability. Wherein lies the error of those who wish to equate a physician removing a respirator from a patient dying of ALS with injecting a lethal drug or providing a pill? Callahan maintains that in the former case, the cause of death would be the underlying disease, whereas in the latter two cases, the cause is the pharmacologic agent. In both cases, however, culpability can be assigned. One might turn off a respirator without consent or for ulterior motives; one might administer a lethal dose unintentionally. In both cases, culpability differs, one being held culpable for the patients death differently in the former instance than in the latter. Thus the error for those who would equate killing and allowing to die

> lies in confusing causality and culpability and in failing to note the way in which human societies have overlaid natural causes with moral rules and interpretations. . . .[j]udgements of moral responsibility and culpability are human constructs. . . . When physicians could do nothing to stop death, they were not held responsible for it. When, with medical progress, they began to have some power over death . . . . moral rules were devised to set forth their obligations. Natural causes were not thereby banished.

> They were, instead, overlaid with a medical ethic designed to determine moral culpability in deploying medical power. (78-79)

Finally, Callahan traces self-determination and individual well-being to their logical conclusions, demonstrating that once PAS instantiates these principles, there will be no logical place, no good moral reason, from which to limit euthanasia and PAS:

> If we really believe in self-determination, then any competent person should have a right to be killed by a doctor for any reason that suits him and no less to be assisted in suicide. If we believe in the relief of suffering, then it seems cruel and capricious to deny it to the incompetent. There is, in short, no reasonable or logical stopping point once the turn has been made down the road to euthanasia or PAS. (83)

Callahan's conclusion proves prophetic in the next essay, by Dan Brock, whose arguments Callahan has just surgically demolished. Brock's "central ethical argument" rests on the "two fundamental ethical values" of "individual self-determination or autonomy and individual well-being." (89) Brock employs these concepts, however, in an unnuanced fashion, failing to attend to the manifold ways in which "choice" is constrained, coerced and constructed by disease and society. Like Callahan, Brock maintains that euthanasia and PAS are not morally distinct, but he takes it one step further. If public policy allows one, says Brock, it should admit the other. Warrants that support PAS should likewise justify voluntary active euthanasia (VAE). This position, paired with his candid expansion of the concept of pain and suffering to include "psychological suffering" unrelated to physical pain, only proves Callahan's point that it will be impossible to limit socially and legally sanctioned PAS. Finally, Brock seeks to equate killing and allowing to die, redefining the latter as "ethically justified killing." Even without Callahan's compelling re-description of this issue or the Supreme Court's reaffirmation of the distinction in its 1997 decisions, Brock's own argument is extremely problematic. The examples he marshals would strike most people as ethically problematic even if legal, such as "when an apparently competent patient makes an informed and voluntary choice to refuse life-sustaining treatment that would restore the patient to full function and a life that most people would consider a life well worth having." (95)

Other problems plague Brock's essay. I will simply mention a few. Brock repeatedly stresses that he is only addressing the moral question of individual acts rather than the legal questions surrounding PAS as a social practice. Yet he repeatedly turns to policy to warrant his own

argument and confuses the legal and the moral. (95-96) He essentially limits the moral determinant to autonomy or self-determination, a position that conflicts even with common sense. He proclaims as timeless truths statements such as: "Individual self-determination has special importance in choices about the time and manner of one's death, including assisted suicide;" (89) ". . . it is especially important that individuals control to the extent possible the manner, circumstances, and timing of their dying and death." (90) After reading Vanderpool's essay, one can only respond "Since when?" Finally, Brock makes a novel move, redefining the "moral center" of medicine as respecting patients' self-determination and promoting their well-being. Again this is asserted rather than demonstrated. As a "value" of relatively recent vintage, patient self-determination deserves a bit longer to mature before becoming medicine's moral center.

Part Three, *Medical Practices and Perspectives*, turns to physician voices. Here Ira R. Byock, M.D. and Howard Brody, MD debate whether or not physician-assisted suicide is an acceptable practice *for physicians*. The arguments are, for the most part, familiar, though both essays are ably done and worth reading. Byock answers in the negative, identifying and challenging assumptions about the medical profession underlying the PAS debate. His responses to these assumptions are thoughtful, reflecting a seasoned medical practitioner's concrete experience. He ultimately concludes that PAS is a call to the medical profession for self-reform and national leadership: "the crisis of end-of-life care presents an opportunity for the profession of medicine to take strong and corrective action and, in so doing, assert a traditional leadership role . . . it can model for society a caring ethic." (128)

Howard Brody argues that assistance in patient suicides is an acceptable practice for physicians, if the practice is carefully circumscribed by oversight and safeguards and made available only to a limited patient population. Proceeding carefully and prudentially, Brody first advances several arguments supporting PAS and then arguments opposing PAS which he deems "also quite weighty." (138) Rather than arguing the "pro" side, however, he instead attempts to show why the opposing arguments are less compelling than they might first appear. These arguments disfavoring PAS include: professional integrity; the adequacy of safeguards; the effect of PAS on hospice care; PAS as the medicalization of death; and physician incompetence to administer PAS. The very statement of these concerns illustrates profound difficulties with PAS, and Brody does little to assuage those difficulties.

His counterarguments are not as compelling as he might wish, for

they require significant assumptions. For example, he counters the charge that PAS undermines professional integrity by redefining the goals of medicine as "healing, preventing illness, and *helping the dying patient to achieve a peaceful and dignified death.*" (141, emphasis added) So redefined, PAS would not undercut professional integrity. Even following Vanderpool's account, however, the redefinition of the goal of medicine as one of assisting death is of relatively recent vintage and of dubious centrality in the self-understanding of physicians. With regard to the effect of PAS on hospice care, Brody proposes an oversight mechanism which includes palliative care specialists on a team that would determine which patients would be "morally appropriate candidates" and recommends that "almost all patients would have to undergo a trial of hospice care before being viewed as potential candidates" for PAS. The implementation of this proposal would require coopting palliative care personnel, requiring them to compromise their fundamental principles and to cooperate with evil both formally and materially. Practically, then, this proposal seems dubious.

Part Four examines PAS from the perspective of *Potentially Vulnerable Patients*. An essay by Kristi L. Kirshner, MD, Carol J. Gill and Christine K. Cassel, MD, provides little new to readers familiar with the debate on PAS. The essay revisits three classic cases of refusal of life-sustaining treatment/assisted-suicide by people with disabilities: David Rivlin, Larry McAfee, and Elizabeth Bouvia. They conclude, aptly, that these cases demonstrate not a desire "to exercise control over their bodies and medical treatment, [but] a desire to escape the socially constructed part of disability—the pain of prejudice, economic deprivation, exclusion from the community, and unnecessarily restricted choices." (163) Their conclusion, however, is intriguing and novel. They note that the emphasis within the disability rights community on "self-determination" may catch it in a contradiction when it then moves to oppose PAS. Rather than endorsing PAS, however, the authors re-read self-determination from the perspective of a disabled person. In the end they conclude unsurprisingly:

> In a country that does not guarantee access to health care or adequate support for dignified assisted living to all its citizens, disempowered populations may be more vulnerable to the pressure to request PAS and other forms of physician assistance in dying. People with abridged choices due to social devaluation and economic oppression who are offered death as an option may be more inclined to choose this path than patients with a number of options available to them, and this may include people who are

elderly, chronically ill, poor and disabled. (164)

Feminist legal scholar Susan M. Wolf contributes an essay entitled *Physician-Assisted Suicide, Abortion, and Treatment Refusal: Using Gender to Analyze the Difference.* This is by far one of the strongest and most interesting articles in the volume from a legal perspective. Wolf offers reasons for considering gender relevant to the debate on physician-assisted suicide. She also carefully re-reads *Planned Parenthood v Casey*, 510 US 1309 (1994), and *Cruzan v Director, Missouri Department of Health*, 497 US 261 (1990), showing how their deployment by the lower courts in *Quill v Vacco*, *Compassion in Dying v Washington,* 122 F3d 1262 (9th Cir 1997), and then *Washington v Glucksberg* radically misread the precedent cases and in no way established a protected liberty interest that would ground a constitutional right to obtain assisted suicide. Her analysis is careful and insightful. Two interpretive points are key: (1) *Cruzan* and *Casey* concern a right to be free of the bodily invasions (unwanted treatment and pregnancy), not a right to be able to obtain an invasion in order to end one's life; (2) *Cruzan* and *Casey* establish an entitlement to live free, not an entitlement to surrender freedom through death. In Wolf's view, PAS, located in a history which valorizes women's self-sacrifice and encourages women's deaths, renders PAS "a fatal threat to women's equality." (170) She closes by reviewing countervailing state interests in opposing assisted suicide.

The final section takes up *Public Policy Options and Recommendations.* An essay by Steven Miles, M.D., Demetra M. Pappas, J.D., and Robert Koepp analyzes three proposals: the Oregon Death with Dignity Act (Measure 16), the Rights of the Terminally Ill Bill of the Northern Territory of Australia (which took effect July 1, 1996, and which was repealed shortly afterwards by the federal legislature of Australia, which may override territorial legislation), and that proposed by Franklin Miller, Timothy Quill, Howard Brody, John Fletcher, Larry Gostin, et al.[4] This essay is equal in rigor, perceptivity, and importance to Wolf's. Reading these proposals against the historical landmarks of bioethics law and policy, their thesis is simple but compelling: that the safeguards designed to enhance respect for patient autonomy undermine two decades of the protection of patient autonomy, resurrect medical paternalism, and discriminate against minors, the incompetent, and disabled persons.

Their arguments are extensive and complex. I will highlight only

4. See *Regulating Physician-Assisted Death*, 331 New England J Med 119-24 (1994).

two of their points. At issue is whether or not PAS represents a fundamental right. If so, it should be made available to all patients, competent and incompetent, physically disabled and nondisabled. Yet, insofar as these proposals disallow "advance directed, substituted judgement, or best interest standards for decision making on behalf of decisionally incapable persons," (215) they discriminate unjustly against those who cannot articulate and/or carry out their own wishes. Moreover, they question physicians' new extrajudicial authority to deny this "treatment option" to legally competent patients because the patients give the wrong reasons or because they do not meet certain criteria: "These restrictions are novel in that the right to refuse life-sustaining treatment, or indeed to consent to (or refuse) any other medical treatment, is nowhere else contingent on terminal illness, proximity to death, or reversibility." (219)

In the final essay William J. Winslade suggests two policy types that might be options in the current situation. The first entails "legally excusing" physicians who admit participation in PAS. Assisted suicide would remain illegal but physicians would be allowed to demonstrate that their action constituted a proper exception. The second policy route would be to "regulate a right to PAS." Although he appears to favor this proposal, he does not advance reasons for its adoption.

This volume offers a valuable model of how to do historical, ethical, and legal analysis. Rather than simply being a collection of disjointed essays, the contributions artfully interact, so that arguments advanced by one author are addressed, refuted, and/or nuanced by others.

Three important general observations about the PAS debate emerge from the confluence of these essays. First, although distinctions and notions of intention, motive, the relationship between cause and effect, the magnitude of effect, the balancing of individual good and the common good are central to law, PAS advocates seek to efface critical conceptual, moral, and legal distinctions. Second, although the impetus for PAS often seems simply to logically extend bioethics as it has developed over the past thirty years, the essays in this volume show how it would in fact be a radical departure from the tradition's wisdom. Third, reading from Vanderpool to Miles, it becomes clear that the issue of power remains a central issue: physicians feel disempowered when facing patient pain, suffering, and death; patients seek power and "control." Even the phrase "allowing to die" betrays the continuing fiction that power over death lies in medicine's hands.

Finally, more attention needs to be paid to how public attitudes

toward and patient experiences of dying are socially constructed and how the practice and discourse coopts both physicians and patients into reproducing particular social values. Too often, physician, patient, or public surveys are invoked without attending to the social location of the population surveyed or to how these opinions have been shaped by social and economic forces. One might argue, for example, that claims that dying is a personal and private matter that individuals ought to control reflect contemporary trends toward commodification of human life; now even the "right to life" is seen as something one owns, property to be disposed of as one sees fit. This attitude of relatively recent vintage fits within a spectrum of like beliefs shaped in large part by the forces of a biotechnologically-driven market.

In the end, this volume provides tools for interpreting continuing developments on the PAS front and stimulates the need for further analysis, whether it be Jack Kevorkian's recent conviction or Oregon's sobering decision authorizing Medicaid payments for PAS—for the poor.

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